Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Spinecare Anesthesia 5734 Spohn Dr. Ste. B Corpus Christi, Tx 78414	MFDR Tracking #: M4-07-2222-01 DWC Claim #: Injured Employe
Respondent Name and Box #: Twin City Fire Insurance Co. Rep Box: 27	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary; taken from the Table of Disputed services: "Authorization was obtained prior to services rendered. (Exhibit #5)."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $378.96
3. EOB
4. Authorization Letter
5. CMS 1500
6. Anesthesia Medical Record

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to this dispute.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Denial Code(s)	Part V Reference	Amount Due
05/18/06	01992 AA QS	W1	1 - 4	$284.22
Total Due:				$284.22

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under procedure code 01992 AA QS for DOS 05/18/06.
2. This service was denied by the Respondent with denial reasons:

- W1 - "Workers comp state fee sched adjust. Provider is not licensed in Texas as an ASC. Resubmit billing on appropriate form."

3. The Respondent reimbursed the Requestor, $0.00 per workers compensation state fee schedule adjustment. Per the ASC directory the Requestor is licensed in Texas as an ASC until February 2009. The Requestor billed on appropriate form CMS 1500. Therefore this dispute will be reviewed per Rule 134.202(b).

   Reimbursement for 01992 AA QS is as follows:

   15 minutes ÷ 15 = 1 unit
   CPT code 01992 =5.00 units + 1 unit = 6 units
   6 units x $47.37(conversion factor)= $284.22

4. Therefore, according to Rule 134.202(c) (1) reimbursement of $284.22 is recommended.

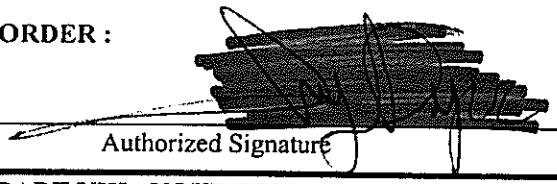
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G
28 Texas Administrative Code Section 134.600

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $284.22 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER :



Authorized Signature	Medical Fee Dispute Resolution Officer	01/22/08
		Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.